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INCREASED HEALTH CARE COST SHARING WORKS AS INTENDED

It burdens patients who need care the most

BY ELISE GOULD

A number of different health care policy proposals that have emerged in recent years share a common goal: make households directly pay for a larger share of most health expenditures by encouraging higher deductibles, higher copays, or higher co-insurance rates. The rationale of such proposals is that too-generous insurance policies (either those provided by employers or public insurance such as Medicare) distort the prices consumers face, and that removing this distortion would allow patients to choose their health care more wisely, hence slowing health care cost growth. The "success" of increased cost sharing hinges on the ability of patients to make educated decisions about their health care purchases much like they do when buying other goods and services such as milk, cars, or cell phone plans.

This brief argues that this is a flawed strategy for health care cost containment. The health care market is unlike other markets; thus, forcing increased cost sharing on American households is a deeply inefficient strategy for trying to contain health care costs. Forcing Americans to pay a higher share of health costs will not induce them to shop around and compare prices when they are experiencing chest pains or their child is suffering from an asthma attack. Further, consumers of health care are in no position to second-guess their doctor when she tells them an MRI is better than an X-ray (and hence worth the higher price) to diagnose a condition. Lastly, unlike other markets, *prices* of health care services faced by consumers bear very little relation to providers' *cost* to supply these services. Hence, these prices provide little to no information for consumers looking to judge the relative efficacy of various health care interventions.

In addition, increased health cost sharing is unlikely to make American health care more affordable to those currently unable to afford it, and will instead likely place the largest burdens on those who need care the most.

Besides being flawed in conception, most concrete policy tools used to increase cost sharing also have serious problems of implementation. This brief discusses a couple of real-world policy proposals to increase cost sharing, such as changing the tax treatment of employer-sponsored health insurance or changing Medicare's premium structure.

This paper's main findings include:

- Most cost-sharing proposals lead to higher out-of-pocket medical costs, hitting those who require a high degree of medical care especially hard.
    - The short-term cost savings achieved as patients respond to increasing out-of-pocket burdens may be realized by reducing medically necessary health care—a penny-wise, pound-foolish result.
    - Cost sharing increases the likelihood of future financial risk.
- Most cost-sharing proposals are poorly targeted for containing overall system costs.
    - They miss the expensive cost drivers.
    - They may lead to consumption of less-effective care and therefore increase overall health care spending.
    - Any cost containment would be driven by reduced medical care, not reduced prices.
- The Affordable Care Act's (ACA) excise tax on high-priced health insurance plans is not well targeted.
    - Health insurance premiums are driven by a variety of influences (e.g., firm size, age of workforce, location, etc.) *unrelated* to the generosity of health plans.
    - Because the tax is triggered by high *premiums*, the tax will hit many workers with ordinary, not exceptionally generous health plans.
    - Because the threshold is indexed in future years at a growth rate that is expected to be slower than the growth of medical costs, in the future it will capture more typical health plans.
    - Any increase in wages that employers may offer to compensate workers for employers' reduced premium contributions to less generous coverage will still lead to a fall in total after-tax compensation, which will increasingly need to be spent on higher out-of-pocket medical costs for those who need care.
- Many proposals to restructure Medicare could increase the financial and health risks faced by the vulnerable elderly.
    - Turning Medicare into a premium-support system—with a voucher set arbitrarily at the value of the second-least-expensive insurance plan—would shift costs to elderly households.
    - Increasing the Medicare eligibility age from 65 to 67 (while simultaneously repealing the ACA's insurance market reforms) will leave many Americans ages 65 and 66 without insurance. Thus, many will put off needed care, costing both their health and financial well-being more in the long run.
    - While cost shifting may lead to workers' wages increasing to compensate them for a loss in employer health insurance contributions, there is no such trade-off for the elderly when it comes to Medicare cost shifting. Additionally, a greater share of elderly Amer-

icans' fixed income will have to go toward health care.

Policy background

A number of proposed health policy interventions—such as taxing employer-sponsored health insurance benefits and restructuring Medicare into a premium-support program—share a key policy feature: They aim to shift health care costs from government and insurance companies onto households. The stated policy benefit of this shift is often short-handed as increasing American households' "skin in the game." The "game" is the purchase of medical care; the "skin" is that Americans will shoulder more of the costs. In other words, Americans will directly face a higher share of total health spending. The theory behind this idea is that people will become more careful consumers of health care and will forgo unnecessary care that they only consumed because insurance reduced its cost to them, all of which will bring down overall health costs.

Increased cost sharing can take many forms. Both taxing employer-sponsored benefits and decreasing government payment of Medicare premiums will encourage the purchase of less expensive health plans in either the employer system or in Medicare. All else equal, fewer dollars toward premiums translates into less comprehensive coverage.

Various particular policy proposals have worked to increase cost sharing. Several increase the taxation of employer-sponsored health insurance benefits. Specific examples include the Affordable Care Act's excise tax, which levies a 40 percent tax on high-priced health plans; the tax exclusion cap set forth by the 2010 National Commission on Fiscal Responsibility and Reform (i.e., the Bowles-Simpson plan); former President Bush's 2005 Tax Reform Panel's recommended cap on the tax exclusion for employer-sponsored premiums; and many other proposals over the years. This brief discusses the specific case of the excise tax in the Affordable Care Act, which creates a strong incentive for employers and workers to purchase less expensive—and hence less *generous*—coverage to avoid the tax.

Another avenue of increased cost sharing is found in proposals to restructure Medicare. This paper focuses on one such proposal: House Budget Committee Chairman Paul Ryan's 2014 budget, which replaces Medicare's current health coverage guarantee with a premium-support payment, in essence creating a voucher for the purchase of health insurance. As with the excise tax, the voucher loses value over time, causing the Medicare population to choose between spending more out-of-pocket on health insurance or more out-of-pocket on purchasing health care.

Both of these avenues of reforming health insurance provision will increase out-of-pocket costs, particularly for enrollees who frequently require health services. As a result, consumers are either burdened with paying higher medical costs, or they may respond to increasing out-of-pocket costs by cutting back on care, some of which may be medically indicated.

This brief argues that these poorly targeted interventions to boost cost sharing are a fundamentally misguided answer to high and rising health costs. The next sections explore these arguments in detail, but in short, pushing costs onto consumers is not a very effective cost-containment device. While these policy measures will undoubtedly reduce the federal government's health expenditures, they will not do much to reduce total system health spending. Unless one is willing to increase cost sharing even for truly catastrophic medical costs, such measures will miss the primary cost drivers in the U.S. health care system—80 percent of health dollars are spent by just 19 percent of (presumably the sickest) health consumers, and 50 percent are driven by just 5 percent of the population (author's analysis of MEPS 2010). In other words, encouraging relatively healthy people to cut back on health care simply misses the vast majority of health care costs. If these less healthy patients driving overall spending (particularly those with chronic diseases)

respond to across-the-board increases in cost sharing by cutting back on all medical care—some of which is extraordinarily *cost-effective* in the long run—they may actually increase overall health costs in later years. In addition, research has shown that cost containment from increasing cost sharing is generally driven by reduced *volumes* of medical care consumed, and not by reduced *prices* (Anderson et al. 2003). Since it is the high prices of American medical care that make us such an outlier in international comparisons, it seems that increased cost-sharing focuses on the wrong problem. Serious solutions to contain health costs may be found elsewhere (e.g., value-based insurance design, all-payer rates, and better care coordination).

The economics and evidence on how cost- and risk-shifting may lower coverage and care

Forcing people into less-comprehensive plans exposes them to higher out-of-pocket costs and greater health-related financial shocks. People value insulation from these shocks—this is the reason people purchase insurance—so forcing them into less-insulating plans has a cost. Shifting health insurance costs onto workers, seniors, and their families may hamper their ability to maintain and secure affordable health care. Such costs have already risen in recent years, resulting in increased out-of-pocket burdens and difficulty in paying medical bills (Collins 2013).

Cunningham (2010) finds growing financial burdens of health care across the socioeconomic distribution, not simply among the poor and uninsured. Himmelstein et al. (2009) find a striking growth in bankruptcies associated with medical costs, even for those households covered by health insurance. Pushing insurance plans to be less comprehensive has the potential to make these financial problems worse.

Not all moral hazard is inefficient

The movement of people into less-comprehensive coverage is often identified as a policy benefit—under the theory that when people have more "skin in the game" (i.e., face a higher share of total health spending) they will become more careful consumers of health care and will forgo unneeded care only previously purchased because they were not facing its full cost. Among economists, this problem is called *moral hazard*. This theory implies there is an optimal level of cost sharing and some of the additional health care purchased by the insured represents economic inefficiency. Nyman (2007) directly questions this theory by arguing that a large portion of moral hazard represents health care that sick consumers would not otherwise have access to without the income that it transferred to them through insurance. This portion of moral hazard—the transfer of income—is efficient and generates a welfare gain.

Nyman illustrates this phenomenon through a useful example of a woman who has just been diagnosed with breast cancer. Without health insurance, she would not be able to afford both the mastectomy and the breast reconstruction needed to correct the disfigurement caused by the mastectomy. With health insurance, she can afford both. One might argue that insurance is inefficient (causing moral hazard) because the breast reconstruction was not medically indicated and she only chose to have that procedure because it was made inexpensive by her insurance. In a social experiment, one could theoretically transfer to her the full cost in dollars (of both procedures) and then view whether she spent it on the mastectomy and the breast reconstruction to determine if it is just the *price reduction* from insurance that provides the incentive or the *income transfer* from insurance that drives her decision-making. If she still purchases both procedures with the cash transfer that she could have used to purchase other goods and services, then this would show that insurance, by relieving a liquidity constraint, leads to efficient decision-making and that presumed inefficiencies from insurance's price distortion are overstated.

This recognition that not all moral hazard is economically inefficient is becoming well-understood in other branches of economics. Chetty (2008) makes similar arguments in the context of unemployment insurance, focusing on the fact that unemployment insurance benefits solve a liquidity problem rather than creating a disincentive to look for work. His research differentiates the moral hazard effect from the liquidity constraint by comparing households that can and cannot smooth consumption through a spell of unemployment with assets or income from other sources, such as a working spouse. Chetty suggests his analysis could apply even more strongly to the case of liquidity constraints in the purchase of health care. On net, it is conceivable that the welfare gain from efficient moral hazard outweighs in both size and importance the welfare loss from excessive medical care. This would be particularly true in the case of individuals with serious illnesses who require expensive treatments.

If policymakers remain determined to make cost sharing a part of a health policy package, the above arguments suggest that taxing health benefits or reducing Medicare premium contributions *for only high-income households* might reduce some of these negative consequences for those at the lower end of the income scale while still raising revenue and reducing spending. This assumes both that the high-income are less likely to be liquidity constrained and that such policies only genuinely hit the high-income.

Cost sharing can lead to medically and economically inefficient decisions

By increasing cost sharing, consumers will be faced with higher out-of-pocket costs when deciding whether to seek medical care. This effective price increase may lead some to cut back on medical spending. For vulnerable populations and those with chronic conditions, many interventions that are avoided may turn out to be health-improving. Research has shown that higher cost sharing could lead families to cut back on medically indicated and effective health care. Goldman, Joyce, and Zheng (2007) find that cuts in plan generosity can lead to reduced compliance with drug therapies for chronic disease, and Buntin et al. (2011) find that enrollment in high-deductible health plans leads to reductions in the use of preventive care. Both Gruber (2006) and Hsu et al. (2006) demonstrate that higher cost sharing is detrimental to the health of the chronically ill.

Overall, the evidence shows that an optimal cost-sharing design may better serve consumers and the health care system when it takes into account all the considerations raised by different patient populations, therapies, and conditions. Consumers simply do not have the necessary information or wherewithal to make many health decisions, and various factors may keep prices from accurately signaling quality or effectiveness. Patients in emergency situations are simply not able to assess hospital quality or direct their own treatment regimen. Patients, in both emergency and non-emergency situations, trust medical professionals to offer the best information and care, unlike sellers in the general marketplace.

Efficient cost-sharing designs cannot be one-size-fits-all. A universally applied excise tax on health benefits or reduced premium contributions to Medicare do not create the right incentives for the creation of the most efficient insurance policy; in fact, one might argue that they are blunt instruments that create no incentives except to purchase less expensive policies. In doing so, they shift costs onto workers, seniors, and their families, hitting those requiring high levels of medical care especially hard.

Cost sharing is a poorly targeted cost-containment device

Many health policy experts have claimed that both taxing employer-sponsored health benefits and restructuring Medicare into a premium-support system could be powerful tools in restraining the overall growth of American health care costs without exposing Americans to much greater financial or health risks. Given that rapidly growing health costs exert real strains on both government

budgets and family incomes, curbing them seems to be a worthy policy goal. As it turns out, these policies have less reach in driving significant cost containment than is commonly recognized.

Decreasing first-dollar coverage through higher deductibles and the like will probably miss many of the most expensive costs in the health system. As previously noted, the sickest 19 percent of the population in any given year accounts for 80 percent of total health spending. This includes people with chronic conditions, acute care needs, end-of-life care needs, etc. An increase in cost sharing among the big-ticket items such as transplants, major life-saving surgeries, or the management of chronic diseases such as diabetes has not been explicitly suggested and is universally recognized to be bad policy.

Swartz (2010) points out that it is often the health care providers and not the patients themselves who are the drivers of high health care spending. To the extent that moral hazard–induced overconsumption of health care is a significant problem, patients already active in the health care system (e.g., under the care of a physician) may be less sensitive to cost sharing. Under a physician's care, the amount of health services consumed is more likely to reflect the decisions made by providers. At that point, patients exercise little control over the medical care they receive. The corollary is that those less active in the health care system may be more sensitive to prices, meaning they are more likely to forgo expensive care if they believe there is less of an immediate medical need for it. Efforts to "bend the cost curve" via increasing costs paid by consumers would be limited to the relatively small share of total health spending borne by this population (akin to the 20 percent of health dollars consumed by 81 percent of the population).

To the extent that consumers do cut back on care in response to increased cost sharing, we noted before that they may well cut back on health-improving medical spending. But they may even cut back on medical spending that is cost effective in the long run. Proponents of increased cost sharing often implicitly suggest that consumers would only be forced to cut back on luxury items (e.g., designer eyeglasses) or medical care that has little or no long-term health effects (e.g., treating a minor skin condition). But a growing body of research indicates that this is not true; increased cost sharing does indeed often crowd out health-improving and cost-effective medical interventions.

McWilliams, Zaslavsky, and Huskamp (2011) find that cuts in plan generosity can lead to higher overall medical spending. Chandra, Gruber, and McKnight (2009) find that there are substantial "offset" effects to broad increases in cost-sharing rates for physician visits and prescription drugs; spending on these categories fell with higher cost sharing, but hospitalization costs rose substantially. In one related study, Goldman, Joyce, and Zheng (2007) find that higher cost sharing for pharmaceuticals is associated with an increased use of overall medical services, particularly for patients with greater needs (e.g., heart disease, diabetes, or schizophrenia).

Likewise, lower cost sharing is associated with a reduction in overall health spending, particularly for those with chronic diseases. For instance, Chernew et al. (2008) demonstrate that cost sharing with lower costs for those for whom the intervention would be most cost-effective (generally the chronically ill) leads to higher compliance. Furthermore, Muszbek et al. (2008) find that increased compliance with drugs for hypertension, diabetes, and a series of other ailments will lead to higher drug costs but lower non-drug costs, leading to overall cost savings. Mahoney (2005) also finds that lowered cost sharing for diabetes patients reduces health costs per plan.

The sum of this important research suggests that increased cost sharing in certain areas (e.g., prescription drugs or primary care) can lead to higher overall costs due to increased health service utilization in other areas (e.g., hospitalization), and that the optimal cost-sharing rate for many chronic conditions and large classes of prescription drugs is very low or even zero. By not differentiating

among medical goods and services based on effectiveness research, increased cost sharing stemming from overly blunt policies such as the excise tax or Medicare vouchers may be an ineffective and potentially harmful tool in making efficient cuts to health care utilization. A careful examination of the growing value-based insurance design literature may produce a more effective policy response.

To the extent that consumers do respond by cutting back on medical care, it becomes clear that any cost containment from these policies is driven by the reduced quantity of medical care consumed, not reduced prices. That is, if increased cost sharing contains costs to any significant extent, it does so by encouraging people affected by it to buy less health care. Anderson et al. (2003) suggest that high medical spending in the United States, as compared with its industrial peers, is actually driven by high prices and not high utilization. To the extent this is true, policies that shift costs onto consumers are not likely to remedy this problem.

Besides problems in conception, specific policies that increase cost sharing also suffer significant problems in the way they are applied. The remainder of this paper looks at two such policies—the Affordable Care Act's excise tax and Rep. Paul Ryan's plan to restructure Medicare—and some of the unique problems their implementation would present.

Excise tax is not well targeted

In March 2010, President Obama signed into law the Affordable Care Act (ACA), commonly known as health reform. As part of health reform, beginning in 2018 a 40 percent excise tax will be levied on health insurance policies with premiums in excess of $10,200 for individual policies and $27,500 for family coverage. The tax applies to the portion of premiums between the threshold and the total cost of the insurance policy. The premium thresholds are adjusted for workers in high-risk industries and for the age and gender of the workforce. In 2019 and beyond, the threshold above which premiums are taxed is indexed to the overall inflation rate plus 1 percentage point, not to the growth of medical costs, which is expected to be higher.

Currently, employer contributions to health insurance premiums are excluded, without limit, from workers' taxable income. Employee contributions are excluded if the employee works at a firm with a cafeteria plan, a plan that allows employees to choose between taxable and nontaxable fringe benefits (e.g., plans that offer flexible spending accounts). Subsidizing compensation paid in the form of health insurance encourages employers to offer health insurance, increasing the number of insured workers. Nevertheless, some argue that limiting this tax exclusion would provide incentives for cost containment because it would make consumers more price sensitive, thereby leading to reduced health expenditures, and it would raise tax revenue that could be used in part to pay for coverage expansions.

In response to the excise tax, a Mercer survey (2009) finds that nearly two-thirds of employers plan to cut health benefits to avoid the tax and a full 7 percent would eliminate their health plan altogether. The Joint Committee on Taxation (2009) revenue estimates assume that only a small share of revenue would actually come directly from the excise tax (as opposed to the large share of revenue from taxed wages), implying that employers and employees alike will shy away from the more expensive plans. Among workers at firms that drop insurance coverage altogether, some workers will become eligible for subsidized coverage in the state health exchanges established by the ACA.

Taxing benefits is often mistaken as a way to get rid of overly generous, or "Cadillac," coverage. However, *expensive* plans are not necessarily *more generous* plans. Many health plans are expensive because the employee population is older or sicker than average, and not because they provide more generous coverage. Gould and Minicozzi (2009) have shown that some of the most powerful predictors of a plan's high cost are the size of the firm and

the age of its workers. Small firms and firms with older workforces tend to have less bargaining power with insurance companies and face higher administrative costs. All else equal, this leads to higher prices for insurance coverage, which may be no more comprehensive than lower-priced coverage for larger firms or those with younger workers. Gabel et al. (2006) have shown that small firms pay premiums 18 percent higher than large firms pay for equivalent health coverage.

Another way to measure plan generosity is to use a health plan's actuarial value, that is, the share of average medical expenditures paid for by the insurance company (instead of by the policyholder). Using actuarial value as a proxy for plan generosity, Gabel et al. (2010) find that only a small share (3.7 percent) of the variation in premiums for family plans is determined by a plan's generosity. Other factors include type of plan (e.g., HMO), industry, and variation in medical costs across the country. Even after including these factors, much of the variation in premiums is left unexplained by plan features. This reinforces that plan prices do not reflect plan value.

To some extent, the health reform law acknowledges this reality and specifically raises the threshold of the excise tax for selected small groups of workers explicitly on the grounds that high cost is not synonymous with high value. For instance, it increases the threshold for health plans covering high-risk professions. However, it does not go far enough to account for the high prices some pay for coverage that is still far from a "Cadillac" standard. Dorn (2009) recognizes this problem and proposes an alternative solution to more clearly target the tax to high-value plans by using actuarial value to measure benefit generosity. One solution he outlines taxes plans above the 75th percentile of actuarial value among all enrollees in employer-sponsored insurance plans, and indexes this threshold to overall inflation over time. This policy prescription still ignores the fact that more comprehensive coverage benefits the least healthy the most.

As previously noted, in 2019 and beyond, the threshold above which premiums are subject to the ACA excise tax is indexed to the overall inflation rate plus 1 percentage point (CPI+1). For instance, if overall inflation grows at an average rate of 2.5 percent while medical care costs rise at 4.0 percent, a growing wedge will be created between a CPI+1 of 3.5 percent and the growth of medical costs. The result is that more and more insurance plans would be subject to the excise tax, leading more employers and workers to demand lower-priced and less comprehensive coverage. As in the past, this growth rate is expected to be lower than the growth of medical costs, thereby capturing more and more health plans in the future—an increasing number of which by any measure would not be considered "Cadillac."

Other policy virtues of the excise tax often overblown

Additionally, proponents of taxing employer-sponsored health insurance benefits often note that if it encourages workers to take less compensation in the form of health insurance premiums, then this could raise other forms of compensation, especially cash wages. Given that in the long run the excise tax will indeed likely lead to non-trivial cuts in employer contributions to insurance premiums, it is certainly possible that cash wages may rise as employer contributions to premiums fall. However, the large majority of these wage increases will simply be absorbed by higher out-of-pocket medical costs incurred with less generous coverage. Given the large variation in annual health spending (i.e., many families spend next to nothing on health costs in a given year while some spend large amounts), many workers could face increases in out-of-pocket costs that far exceed the potential addition to cash wages that accompanies the imposition of the excise tax. On average, after-tax, *after–health care* wages will rise much less than proponents often claim. Finally, characterizing the potential for cash wages to rise in response to the tax as simply "a raise" for American workers is not correct. Even if cash wages rise in response (however doubtful in the current economy), these rising wages only come as

other forms of compensation are falling. Further, because some compensation that was previously being subsidized through tax policy is now being taxed, the result is an unambiguous cut, not a raise, to total after-tax compensation.

Lastly, because better-paid workers are generally more likely to have employer-sponsored insurance (ESI), and because the tax benefit to having ESI rises with income, anything that reduces this ESI-related tax benefit is often described as a "progressive" tax increase. However, McIntyre (2009) makes the additional point that, as a share of income, taxing ESI does not unambiguously increase the progressivity of the tax system across every segment of the income distribution. While many low-income households do not enjoy access to ESI, high-income households are required to contribute only a small share of their income to pay the tax because there is a limit to how much any household would want to take income in the form of health insurance. For instance, compared with the home mortgage interest deduction, the tax advantage given to health insurance is more tightly distributed, as house prices vary more widely than do health premiums. McIntyre calculates the marginal federal income and payroll tax rate on converting a portion of tax-exempt wages (in this case, health insurance) into taxable wages. He finds that if health premiums were taxed as wages, the tax rate (including the payroll tax) would be relatively flat across income groups. Given the tight distribution of health premiums and relatively flat marginal tax rates, McIntyre estimates that the excise tax, as a share of income, would be 10–20 times as high on middle-income families as on the rich, reducing the overall progressivity of the tax system.

Medicare restructuring according to Paul Ryan's 2014 budget

House Budget Committee Chairman Paul Ryan's 2014 budget proposes several changes to Medicare in an effort to increase competition and stem the program's growth rate (Ryan 2013). His plan restructures traditional Medicare into a system where the government pays a set rate and seniors shop for their plans in a competitive Medicare Exchange. The government contribution is set at the lesser of the second-least-expensive private plan or traditional Medicare. So in the first year, those wishing to remain in traditional Medicare will be able to with no additional costs.

However, in future years, the value of the voucher will be set according to a competitive-bidding process and (more importantly) cannot see its growth exceed growth in overall GDP plus 0.5 percentage points—a rate likely to be slower than actual health cost growth. Given the wedge between the increase in health costs and government contributions to premiums, over time the voucher will lose value relative to desired health plans for purchase. Van de Water (2013) argues that the only way to keep Medicare cost growth within the target spending level under the Ryan proposal is to limit the annual increase in the amount of the voucher. Over time, this pushes both the cost of health insurance and the cost of health care onto seniors.

While an argument can be made that workers who face a loss in employer contributions to health insurance will see higher wages to compensate, in the case of Medicare, seniors will clearly experience a welfare loss. There will be no increase in Social Security to offset the increased cost sharing as a result of premium support that refuses to keep up with medical inflation. Forcing cost sharing on seniors will increase their economic and health vulnerability without any offsets that increase their financial well-being. Any increases in out-of-pocket spending as a result of less generous plans will lead to a higher share of the elderly being financially insecure. Cooper and Gould (forthcoming) find that a 50 percent increase in medical spending on premiums and out-of-pocket medical care among the elderly Medicare population will increase the share of the economically insecure elderly by nearly 10 percent, from 48.0 percent to 52.6 percent.

Furthermore, in its analysis of a similar plan Rep. Ryan proposed two years ago, the Congressional Budget Office (CBO) estimates that replacing traditional Medicare with a premium-support model would not yield the touted cost containment (CBO 2011). CBO points to two major factors: Private plans have higher administrative costs and profits than Medicare, and payment rates to providers are higher in private plans because they have less negotiating power than does Medicare. Not only will seniors bear more of the health cost burden, but the overall burden may increase as Medicare loses its comparative advantage in the health care marketplace.

Ryan's plan also raises the eligible age for Medicare from 65 to 67 by 2035. As his plan also proposes to repeal many of health reform's provisions, increasing the Medicare eligibility age will cause many to put off needed care, costing both their health and financial well-being more in the long run (McWilliams et al. 2007). Without a regulated insurance market that assures those ages 65 and 66 an alternate source of affordable coverage, they may enter the ranks of the uninsured with all the problems that ensue from that status, particularly the inability to receive necessary care when needed.

Conclusion

Both the excise tax on high-cost employer-sponsored health insurance plans and restructuring Medicare into a voucher system will shift costs onto workers, seniors, and their families. For those who require extensive medical care, such policies may result in financial stress and/or medical sacrifice. They may lead some to be even more costly consumers of health care. For that price, these policies may ease the federal budget, but research shows that they will do little to contain overall health spending. Furthermore, they put all the burden of cost containment on consumers without giving them the tools to make more fully informed medical decisions.

Serious solutions to contain health costs may be found elsewhere. Experts are required to make these decisions, and such methods can be instituted, for instance, by the Independent Payment Advisory Board established by health reform to restrain Medicare cost growth without sacrificing coverage or quality of care. Among a series of alternatives Holahan et al. (2011) estimate to contain health system costs, the one with the greatest effect is the establishment of an all-payer rate setting system, a system that would ensure that rates were controlled for all, regardless of how they received insurance. Laugesen and Glied (2011) offer ways to create incentives for the consumption of more medically effective and cost-effective care by reducing the payment disparities between physicians and specialists. Buntin and Cutler (2009) explore alternative savings mechanisms such as investments in health information technology and payment system reforms. If policymakers are determined to increase cost sharing, careful research (including research that has yet to be conducted) should be consulted to avoid increasing cost sharing where it would be destructive to health or economic security. Doing so, rather than using the blunt tool of a tax on high-priced plans, may provide a more effective incentive to rein in the high costs of the U.S. health care system.

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